STATE PLAN UNDER TITLE XIX of the SOCIAL SECURITY ACT

Managed Health Care

STATE PLAN DEFINED HMO

The State Medicaid agency may contract with managed care entities who have been issued a Certificate of Authority, under the statutory and regulatory authority of the New Jersey Department of Health and the New Jersey Department of Insurance, to operate as a health maintenance organization (HMO), Statewide or within a geographic area of the State of New Jersey.

Under State regulations, an HMO must provide or arrange for basic health care services and any other services mandated by State law or regulation. In addition, an HMO may provide any supplemental health care services which are in conformity with applicable laws and regulations.

Basic health services include health professional services, such as, but not limited to, physician services, radiology (diagnostic and therapeutic), laboratory, non-physician health care practitioner services, and 24 hour emergency services-seven days a week. Institutional services are considered basic health services and include, but are not limited to, inpatient hospital, home health services, and out-of-area hospital services for accidental injury or emergency illness. Support services considered basic health services include, but are not limited to, ambulance services, health education services, nutritional education and counseling, medical social services, preventive health care services, including voluntary family planning services and treatment for infertility.

In addition to these medical services, to contract with Medicaid the HMO must also provide and arrange for EPSDT services. Supplemental health care services such as nursing facility services may be provided but are not considered basic health services for State contracted HMOs.

The HMO must demonstrate to the Medicaid agency through the use of mapping and provider listings the adequacy of the provider network in relation to the Medicaid population and the services it will provide.

The HMO must demonstrate financial soundness according to State regulation and the protection against insolvency is assured prior to the issuance of a Certificate of Authority. The HMO must continue to demonstrate such protection on an ongoing basis to the Medicaid program by submitting quarterly financial reports to the Medicaid agency.

TN 93-19 Approval Date JAN 27 1994

Supersedes TN New Effective Date NOV 1 - 1993

STATE PLAN UNDER TITLE XIX of the SOCIAL SECURITY ACT

Managed Health Care

In accordance with 42 CFR 434.32 and 42 CFR 434.34, the HMO must have established an internal Utilization Management/Quality Assurance Program, including grievance procedure/complaint system, that assures access and quality of care for its Medicaid enrollees.

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: New Jersey

DEFINITION OF A STATE PLAN-DEFINED HEALTH MAINTENANCE ORGANIZATION (HMO)

For purposes of this amendment, the Garden State Health Plan, a public Health Maintenance Organization (HMO), is a subdivision of the single state agency, the New Jersey Department of Human Services through the Division of Medical Assistance and Health Services which administers the Medicaid (Title XIX) program, and provides services as set out in 42 USC 1396b(m)(1)(A)(i) and is organized pursuant to Section 1903(m)(6) of the Social Security Act.

The HMO is organized primarily for the purpose of providing health care services.

The services provided by an HMO to its enrollees are as accessible to said enrollees as those services are to non-enrolled Medicaid recipients within the area served by the HMO. Individuals who would otherwise lose eligibility before the minimum enrollment period may be deemed eligible for six month periods beginning on the date the individual's enrollment with the Garden State Health Plan becomes effective, pursuant to 1902(e)(2)(A).

The Garden State Health Plan has made satisfactory provision against the risk of insolvency. Medicaid enrollees will not be liable for the HMO's debts if the HMO should become insolvent.

The funds used to operate the Garden State Health Plan will be maintained in separate accounts, an administrative account and a service account, apart from the Division of Medical Assistance and Health Services general accounts.

The State agrees to submit annually a separate document, subject to HCFA prior approval, which:

(i) describes in full detail the State's rate setting methodology for GSHP and demonstrates that the payments are made on an actuarially sound basis according to Section 1903(m)(2)(A)(iii).

The GSHP capitation rate setting methodology is an experience based system. Rates are calculated on the basis of the paid claims experience for services included in the GSHP for a base year and projected forward to the rate year with adjustments for inflation and other Plan developments. These projected rates are labeled the Adjusted Average Cost per Eligible (ACPE). Twenty six rates are set for each of the ten counties in which the Plan operates to reflect experience correlated with the age, gender, and Medicaid eligibility category of Title XIX eligible individuals.

Capitation rates paid by the State to the GSHP are all-inclusive, i.e. they include administrative as well as service costs. Capitation rates paid by the GSHP to Physician Case Managers are further partitioned into Ambulatory and Inpatient ACPEs which, in turn, are divided into payment categories which include prepayment, case management fee, referral and inpatient trust funds, and referral and inpatient reinsurance accounts.

The GSHP employs experience rating, the method most commonly used by commercial insurers, since this method allows for prepaid rates to vary among groups, defined by various parameters, in accordance with differences in historical utilization patterns. Actuarial methods for rate setting were rejected since historical data of great precision and high levels of disaggregation were available. Thus, those actuarial techniques which, in part, compensate for the absence of such deterministic information, were unnecessary. Subsequent experience confirms this approach. For example, a study of actuarial rate-setting for the Medicaid Program in Wisconsin established that the difficulties and costs of implementing such a system exceeded the potential savings to the state (e.g., adjustments of rates for age and sex of each HMO enrollee were considered). The GSHP does however incorporate these adjustments, as well as county of residence and category of eligibility, as part of its rate setting.

(ii) The State also agrees to submit annually a separate document, subject to HCFA prior approval, which demonstrates that Federal matching payments under Medicaid for the services furnished by the GSHP will be lower than if the same services were to be provided by the State on a fee-for-service basis (Section 1903(m)(6)(B)(iii)).

Federal matching payments under Medicaid for services under the Garden State Health Plan (GSHP) will be lower than if the same services were to be provided by the State on a Fee-for-service (FFS) basis for two reasons.

- The State pays the GSHP an all-inclusive capitation rate which is lower than the Average Cost per Eligible (ACPE) for the actuarially equivalent population.

Because of the all-inclusive nature of this rate, administrative costs as well as service costs are included.

- The Plan pays its Physician Case Managers (PCMs) a capitation rate which allows for adequate reinsurance reserves. These reserves, together with the operation of the GSHP's Fund system, generate additional savings to the State and Federal payors.

The Division of Medical Assistance and Health Services will contract for PRO review of the quality of services provided by the GSHP, with an organization that reviews services pursuant to a contract under Section 1876 in accordance with Section 1903(m)(6)(B)(iv).

The Division will submit annually to HCFA supporting documentation describing the GSHP and documentation between the GSHP and the Division of Medical Assistance and Health Services concerning implementation of the undertaking for the purpose of enabling the Regional Office to determine approval and re-approval on an annual basis (Section 1903(m)(6)(C)).

The GSHP recognizes that it is not eligible for a Section 1915(b) waiver in accordance with 1903(m)(6)(D).

The Division will comply with 1902(e)(2)(A) in guaranteeing a person's Medicaid eligibility for GSHP benefits for 6 month periods from the date of enrollment in the GSHP.